COMMONWEALTH of VIRGINIA

Department of Health Professions
Board of Medicine

John W. Hasty
Director of the Department

William L. Harp, M.D.
Executive Director of the Board

6606 West Broad Street
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February 8, 2002

Rodger A. Fraser, M.D.
9960 Racquet Club Lane
Apartment 3-B
Glen Allen, VA 23060

SERVICE BY HAND

RE: License No.: 0101-053053

Dear Dr. Fraser:

I enclose a certified copy of the Virginia Board of Medicine's Order of Summary Suspension entered February 8, 2002, affecting your license to practice medicine in the Commonwealth of Virginia. Effective immediately, it shall be unlawful for you to treat patients, prescribe medications, or otherwise practice medicine, or hold yourself out as a licensed physician in the Commonwealth of Virginia. In accordance with Sections 54.1-105, 54.1-110, 54.1-2400, 2.2-4020 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), you are hereby given notice that the Virginia Board of Medicine ("Board") will convene a formal administrative hearing to receive and act upon evidence that you may have violated certain laws governing the practice of medicine in Virginia, as set forth in the attached Statement of Particulars.

The formal administrative hearing will be held in accordance with the provisions of Sections 54.1-2400(11) and 2.2-4024.F of the Code, before a panel of the Board, with a member of the Board presiding. You have been scheduled to appear before the Board on **Wednesday, March 20, 2002, at 9:15 a.m., in the offices of the Department of Health Professions, 6606 West Broad Street, Richmond, Virginia.** A map is enclosed for your convenience. Your presence is required thirty (30) minutes in advance of the appointed time. Please report to the 4th floor receptionist, who will direct you to a waiting room. Please be seated in the waiting room and you will be called when the Board is ready to meet with you.

You have the following rights, among others: to be represented by legal counsel, to have witnesses subpoenaed on your behalf, to present documentary evidence and to cross-examine adverse witnesses. Should you wish to subpoena witnesses, requests for subpoenas must be made in writing in accordance with the enclosed Instructions for Requesting Subpoenas.

Should you or Assistant Attorney General Emily Wingfield wish to make pre-hearing motions, each of you is directed to file motions in writing, addressed to me at the Board office, at least by **March 6, 2002**. You have the right to the information which will be used by the Board in reaching a decision regarding this matter; therefore, I enclose Commonwealth's Exhibits 1-4 for your review. Please note that these documents are enclosed only with the original notice sent by certified mail, and must be claimed at the post office. If you have any questions or objections regarding the content of this package, you should contact Mykl Egan, Senior

Adjudication Analyst, at (804) 662-7592. If you have not raised any objections by **March 6, 2002**, these exhibits will be distributed to the Board members for their review prior to your hearing, and will be considered by the Board as evidence when it deliberates upon your case. Further, to facilitate this hearing, the Board requests that you provide to Renee Dixson, Discipline Case Manager, Virginia Board of Medicine, 6606 West Broad Street, Richmond, Virginia 23230, fifteen (15) copies of any documents you intend to introduce into evidence by **March 6, 2002.**

Absent good cause shown to support a request for a continuance, the formal administrative hearing will be held on March 20, 2002. A request to continue this proceeding must state **in detail** the reason for the request and must establish good cause. Such request must be made in writing to me at the address listed on this letter and must be received by 5:00 p.m. on **March 6, 2002.** Only one such motion will be considered. Absent exigent circumstances, such as personal or family illness, a request for a continuance after **March 6, 2002,** will not be considered.

You may be represented by an attorney at the formal administrative hearing. If you obtain counsel, you should do so as soon as possible, as a motion for a continuance due to the unavailability of counsel will not be considered unless received by **March 6, 2002.** Further, it is your responsibility to provide the enclosed materials to your attorney.

Please indicate, by letter to this office, your intention to be present.

Sincerely,

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

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cc: Harry C. Beaver, M.D., President, Virginia Board of Medicine
Director's Office, Department of Health Professions
James L. Banning, Director, Administrative Proceedings Division
Emily Wingfield, Assistant Attorney General
Mykl Egan, Senior Adjudication Analyst
T.C. Butera, Senior Investigator (83924)
Renee S. Dixson, Discipline Case Manager, Board of Medicine
Senior Administrative Assistant, Board of Medicine

Enclosures:
Order of Summary Suspension
Commonwealth's Exhibits 1-4
Statement of Particulars
Attachment I
Virginia Code Sections:
54.1-105
54.1-110
54.1-111
54.1-2400
54.1-2910.1
54.1-2914
54.1-2915
2.2-4020
2.2-4021

2.2-4024
Board of Medicine Regulations:
18 VAC 85-20-280
18 VAC 85-20-300
Map
Instructions for Requesting Subpoenas

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: RODGER A. FRASER, M.D.
License No.: 0101-053053

STATEMENT OF PARTICULARS

The Board alleges that Rodger A. Fraser, M.D., may have violated Sections 54.1-111.A(8), 54.1-2910.1(7), 54.1-2915.A.(1), (4) and (3), as further defined in Section 54.1-2914.A.(1), (7), (8), and (11) of the Code of Virginia (1950), as amended, and Sections 18 VAC 85-20-280(A)(1) and (C), and 18 VAC 85-20-300 of the Virginia Board of Medicine Regulations, in that:

1. On or about November 20, 2001, Patient A, accompanied by her boyfriend, presented to Dr. Fraser at the Commonwealth Women's Clinic, Falls Church, Virginia, for an elective abortion. Patient A's last monthly period was documented on her intake form as "Aug. 01 9/2" (sic). Dr. Fraser recorded that his bimanual examination confirmed an 11 to 13 week-sized uterus. Without performing an appropriate pre-operative evaluation, Dr. Fraser initiated the abortion. Dr. Fraser stated to the Department of Health Profession's investigator ("Department's investigator") that the fetal parts he removed were more developed than an 11 or 12 week-old fetus; instead, they were comparable to that of an 18 to 20 week-old fetus.

2. During the procedure, Dr. Fraser perforated Patient A's uterus multiple times, damaging her bowel and causing her to hemorrhage. Dr. Fraser instructed the staff to call paramedics for transport to a local hospital.

3 At no time did Dr. Fraser speak to Patient A or her boyfriend, nor did Dr. Fraser explain to Patient A or her boyfriend the reason for her transport to the hospital.

4. Patient A was taken to INOVA Fairfax Hospital via ambulance. Dr. Fraser abandoned Patient A when he sent her to the hospital with insufficient documentation or guidance explaining Patient A's condition.

Dr. Fraser failed to directly communicate with any of the hospital's physicians until after the hospital staff took multiple affirmative and active steps to contact Dr. Fraser. Specifically, Dr. Fraser stated in his interview with the Department's investigator that he informed an emergency room nurse that he was sending in a patient, but failed to speak to a physician on duty and failed to sufficiently explain the patient's condition. According to hospital staff, the medical record he sent with Patient A was illegible. Shortly after transfer, attempts by the hospital staff to contact Dr. Fraser regarding Patient A's condition were unsuccessful. When Dr. Fraser eventually contacted a resident later that night, the hospital had already determined the severity of the injury. During this conversation, Dr. Fraser reported to the resident a larger than expected fetus, and stated that he saw an undamaged loop of bowel after removing several fetal parts. This information was used to re-confirm the hospital's findings. Until Dr. Fraser returned the hospital's calls, all communications by Dr. Fraser to any doctors at the hospital was through third parties.

5. Patient A was admitted to INOVA Hospital and underwent an emergency exploratory laparotomy, which revealed a large gaping defect in the low posterior uterus and a mesenteric injury to the sigmoid colon with resultant vascular compromise. Further, an ossified fetal head with a biparietal diameter of 5.6 cm was extracted from the uterus. Due to the extent of her injuries, Patient A required a supracervical hysterectomy and a Hartmann's procedure with end colostomy.

6. Upon review of the evidence, Dr. Fraser made numerous inconsistent statements and medical record entries. Specifically:

- In Dr. Fraser's letter to the Board, he stated that he introduced himself to Patient A, explained the procedure, and examined her chest and heart. However, in his interview with the Department's investigator, Dr. Fraser said he did not speak to Patient A because she did not speak English. The investigator confirmed the fact that Patient A could not speak English, and confirmed that neither she nor her boyfriend spoke with Dr. Fraser

- In his letter to the Board, Dr. Fraser stated that no ultrasound was taken because the machine was either broken or out of film. However, in his interview with the Department's investigator, Dr. Fraser said that a nurse did not take an ultrasound before the procedure because she did not have time. He later stated that he performed an ultrasound on Patient A during the procedure. When asked about the identity of the nurse, he could not remember her name, and he believed that she was no longer with the clinic.
- In his letter to the Board, Dr. Fraser stated that a staff member from the clinic followed Patient A to the hospital; however, he did not identify the staff member. Further, the hospital records do not indicate that a staff member was present at the hospital's emergency room.
- In his initial exam, Dr. Fraser noted the age of the fetus at 11 weeks on the physical examination form, yet when the hospital was contacted, Dr. Fraser estimated the age of the fetus to be 15 to 20 weeks. Also, on the Gross Pathology Report form, Dr. Fraser noted that the placenta was the only product of conception examined and identified and the tissue appeared normal. Further, he recorded that the tissue was consistent with a complete abortion of either an eight week or eighteen week-sized fetus, and Patient A was sent to the recovery lounge in good condition.
- In his letter to the Board and his statement to the Department's investigator, Dr. Fraser stated that the cause of Patient A's bleeding was placenta previa and that he confirmed this finding by ultrasound. The clinic's records contain no reference to placenta previa and Dr. Fraser did not report this condition to staff or physicians at the hospital.

7. Dr. Fraser failed to list his practice at Commonwealth Women's Clinic, Falls Church, Virginia, as a primary or secondary address on his Virginia Practitioner Profile.

Please see Attachment I for the identity of the patient referenced above.

FOR THE BOARD

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

DATE: 2/8/02